

MS STATE VETERANS AFFAIRS BOARD

3466 Hwy 80 East

P.O. Box 5947

Pearl, Mississippi 39285-5947

STATEMENT OF ATTENDING PHYSICIAN FORM

Veteran's name: _____

Veteran's claim #: _____

Guardian's name: _____

Relationship to veteran: _____

Guardian's address: _____

Patient's current symptoms and complaints

Diagnosis of patient's disabilities:

1. _____ Severity _____

2. _____ Severity _____

3. _____ Severity _____

4. _____ Severity _____

5. _____ Severity _____

How often and under what circumstance does patient leave home or premises?

What aids are required for locomotion or movement?:

- ☐ Cane ☐ Walker ☐ Braces
☐ Wheel Chair ☐ Crutches ☐ Lift Chair/Sling

1. Is patient bedridden? _____

2. Is patient blind? _____

3. Is there loss of anal sphincter control? _____

4. Is there loss of bladder sphincter control? _____

5. Can patient walk and get around without assistance? _____
6. Can patient dress and undress without assistance? _____
7. Can patient use the bath/toilet without assistance? _____
8. Can patient wash and keep him/herself clean & presentable? _____
9. Can patient feed him/herself without assistance? _____
10. Can patient protect him/herself from the hazards of life? _____

Is patient in a nursing home? _____

If so, what level of care?

- ☐ Personal Care
- ☐ Intermediate Care
- ☐ Skilled

Name of nursing home: _____

Address: _____

Physician's Signature: _____ Date: _____

Address of Physician: _____